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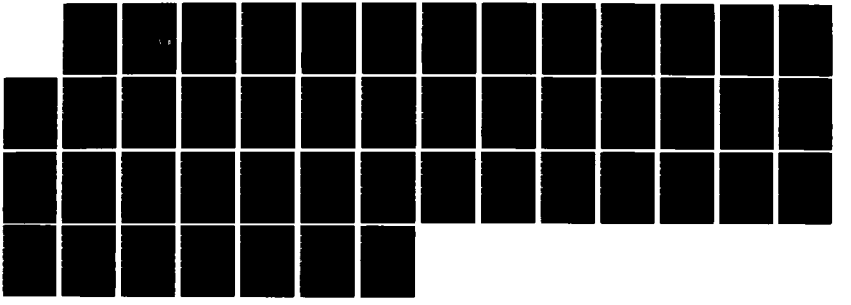

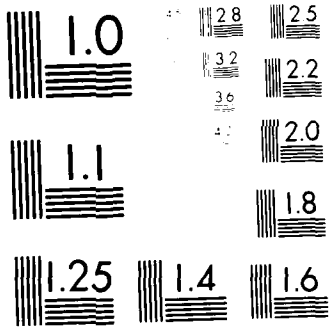

United States General Accounting Office

GAO

Briefing Report to the Honorable
Daniel K. Inouye,
United States Senate

July 1986

DOD HEALTH CARE

Implications of Outpatient User's Fee for Nonactive Duty Beneficiaries

GAO/HRD-86-77BR

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

July 14, 1986

B-223486

The Honorable Daniel K. Inouye
United States Senate

Dear Senator Inouye:

At your request, we have analyzed the implications of imposing a user's fee on outpatient visits to Department of Defense (DOD) medical treatment facilities by nonactive duty beneficiaries. Specifically, you asked us to develop information on

--the revenue that could be generated from a user's fee,

--the extent to which beneficiaries may be unnecessarily using outpatient services at military health care facilities,

--the user's fee charge necessary to make the cost per outpatient visit at DOD facilities equitable with the average charges paid by Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) beneficiaries, and

--other issues that may affect a decision to impose such a fee.

Much of the information needed to make reasonably accurate estimates of revenue that could be generated by a user's fee either was not available or could not be quantified. Therefore, we had to make assumptions about (1) what a fee per visit might be, (2) the workload unit on which a fee could be assessed, (3) how a fee might affect beneficiaries' use of outpatient services, and (4) costs to administer a fee program.

We developed our revenue estimates on the basis of $5 and $10 per visit since these were the amounts most frequently mentioned in congressional documents. Estimates were developed on two definitions of a work unit--one used by DOD and one that groups visits for the same condition. We calculated, based on a study by the Rand Corporation, the effect of beneficiary use if a user's fee of $5 and $10 were imposed. Finally, we estimated

the costs to administer a user's fee program based on data supplied by the Army, the Air Force, and the Bethesda Naval Hospital. The results of our analysis are summarized below and discussed in the briefing report.

We estimate that if a $5 user's fee had been imposed in fiscal year 1984, net revenue of between $231 million and $467 million could have been generated for the 5-fiscal-year period 1984-88 depending on the workload unit on which the fee was imposed. We estimate that a $10 fee would have produced net revenue of between $700 million and $1.5 billion for the same period.

DOD believes that a user's fee would cause workload shifts from DOD to CHAMPUS. The Congressional Budget Office believes that such a fee would have the opposite effect. We did not determine the effect of these potential shifts on revenue because of the difficulty in quantifying the workload shifts from DOD facilities to CHAMPUS and because we could not find a valid method of predicting the effect of the shifts from CHAMPUS to DOD facilities.

The extent to which beneficiaries unnecessarily use outpatient services at DOD facilities and the extent to which a user's fee would affect the incidence of unnecessary use are not quantifiable because no acceptable method exists for defining or measuring unnecessary use.

Sufficient data do not exist to precisely determine what user's fee at DOD facilities would be comparable to the charge paid by CHAMPUS beneficiaries. Estimates of CHAMPUS beneficiary costs provided by CHAMPUS and estimates we made based on CHAMPUS data varied widely. Based on these two sets of data, a user's fee of between $16 and $30 per outpatient visit would be necessary to make charges at DOD facilities comparable to those paid by CHAMPUS beneficiaries.

DOD opposes a user's fee, believing it would worsen beneficiaries' financial position and adversely affect morale, recruitment, retention, and readiness. DOD did not provide data to support this belief. While the financial impact would vary among beneficiaries, on the average a user's fee of $5 or $10 would represent a small percentage of family income.

Imposing a user's fee on non-DOD uniformed service facilities (e.g., those of the Coast Guard) should be considered in structuring a user's fee program. If a fee were to be imposed only at DOD facilities, beneficiaries may use the other uniformed service facilities to avoid paying a fee.

In commenting on a draft of this report, the Assistant Secretary of Defense (Health Affairs) stated on June 12, 1986, that DOD is reluctant to impose a fee until it is able to obtain more reliable data. According to the Assistant Secretary, DOD will conduct a feasibility study in fiscal year 1987 to include an assessment of all available data in both the government and civilian sectors. He said a user's fee would be implemented if the assessment supports such action.

Although DOD believes that further study may be needed regarding the imposition of a user's fee, it should be noted that reliable data do not exist regarding many of the factors related to such a fee. Thus, we believe that a feasibility study initiated by DOD should be directed first toward (1) establishing specific objectives for a user's fee program and (2) determining the amount of a fee that would be needed to achieve those objectives.

As arranged with your office, copies of this briefing report are being sent to the Chairmen, Senate and House Committees on Appropriations and Armed Services; the Director, Office of Management and Budget; the Secretary of Defense; the Secretaries of the Army, Navy, and Air Force; and other interested parties. We will also make copies available to others upon request.

Should you need additional information on the contents of this document, please call me on 275-6207.

Sincerely yours,

David P. Baine

David P. Baine
Associate Director

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ABBREVIATIONS

ADP	automatic data processing
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPI	Consumer Price Index
DOD	Department of Defense
NOAA	National Oceanic and Atmospheric Administration
OCHAMPUS	Office of CHAMPUS
PHS	Public Health Service
RAPS	Resource Analysis and Planning System
UCA	Uniform Chart of Accounts

IMPLICATIONS OF OUTPATIENT USER'S FEE FOR NONACTIVE DUTY DOD BENEFICIARIES

INTRODUCTION

The Department of Defense (DOD) operates a worldwide health care system to provide medical care to active duty U.S. military forces and, when space, staff, and other resources are available, to other eligible beneficiaries--dependents of active duty members, retirees, and dependents of retirees and deceased members. According to DOD's 1984 Health Care Survey, 9 million beneficiaries are eligible for health care in the system--2.3 million active duty members, 2.7 million dependents of active duty members, and 4 million retirees and dependents of retirees and deceased members. The system consists of (1) 168 hospitals and 546 ambulatory care facilities, which provide care directly to eligible beneficiaries, and (2) a supplemental program of civilian care for other than active duty members known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In fiscal year 1985, the direct care system cost about $8.0 billion to operate, including medical facility construction, while CHAMPUS costs amounted to about $1.4 billion.

For inpatient care, most beneficiaries[1] are required to pay a small daily fee to cover subsistence costs. Outpatient care is free to all beneficiaries. The Secretary of Defense is authorized, but not required, by 10 U.S.C. 1078(b) to establish minimal charges (user's fee) for outpatient care at DOD facilities to dependents and survivors of active duty or retired members as a restraint on excessive demand. This legislation does not give the Secretary authority to impose similar charges on care received by military retirees except on a demonstration basis. As of February 1986, DOD had not established a user's fee for outpatient care at its facilities.

Nonactive duty beneficiaries made about 30 million outpatient clinic visits to DOD treatment facilities in fiscal year 1983--the latest year for which complete data were available at the time of our review. Active duty service members made about 12 million outpatient visits during the same period.

To assist in the congressional decision making concerning the user's fee, Senator Daniel K. Inouye requested us to develop information on

--the revenue that could be generated from a user's fee (see p. 13),

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[1]Hereafter, as used in this report, the term "beneficiaries" refers to other than active duty personnel.

--the extent to which beneficiaries may be unnecessarily using outpatient services at military health care facilities (see p. 19),

--the charge necessary to make the cost per outpatient visit at DOD facilities equitable with the average fee paid by CHAMPUS beneficiaries (see p. 20), and

--other issues that may affect a decision to impose such a fee (see p. 21).

Objective, Scope, and Methodology

The objective of our review was to develop information to answer the questions raised by Senator Inouye. Much of the information necessary to make reasonably accurate and reliable estimates of revenue that could be generated by imposing a user's fee for outpatient visits at DOD medical facilities either was not available or could not be quantified. Therefore, we made assumptions about the many factors associated with estimating gross and net revenues. These included

--what an appropriate user's fee might be,

--the workload unit on which it could be assessed,

--how a fee might affect beneficiaries' use of outpatient services at DOD medical facilities, and

--additional costs involved in administering a user's fee program.

For calculation purposes, we chose per-visit fees of $5 and $10 because these were the amounts most frequently mentioned in recent congressional reports.[2]

In developing the workload measures, we used two methods of counting outpatient visits. The first counted each clinical encounter as a visit. For this we obtained data from DOD's Resource Analysis and Planning System (RAPS), an automated analytical tool for estimating current and future medical system requirements. The RAPS information was based on DOD's standardized medical facility cost accounting system, the Uniform Chart of Accounts (UCA), and modified to categorize visits by beneficiary type. In UCA, each clinical encounter is counted as a separate visit. For example, if a patient visits a primary care

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[2]House Report of the Committee on Appropriations, Dec. 2, 1982 [97-943]; Senate Report of the Committee on Appropriations, Sept. 23, 1982 [97-580]; and Senate Report of the Committee on Appropriations, Nov. 1, 1983 [98-292].

clinic and two specialty clinics on the same day, even for the same condition, UCA counts it as three visits. Similarly, UCA counts a physical examination that requires the patient to visit four different clinics as four visits. Telephone consultations are also counted as visits.

The second method we used to count workload entailed grouping clinical encounters. We obtained data concerning these groupings from the 1978 Military Health Services Utilization Survey conducted by the Office of the Assistant Secretary of Defense (Health Affairs), the latest such data available at the time of our work. This survey collected 1977 data from beneficiaries on their use of DOD-sponsored health care programs. Although the survey did not clearly define an outpatient visit, we believe it is reasonable to assume that beneficiaries' perceptions of an outpatient visit would be more comparable to a grouped workload unit than to a visit as defined in UCA and currently used in DOD.

To determine the effects of a fee on beneficiaries' demand for outpatient services at DOD facilities, we estimated the extent to which demand would vary in response to a change in the fee for each year between 1984 and 1988. We assumed that workloads would not shift between DOD medical facilities and CHAMPUS because of the difficulty of predicting the effect of potential workload shifts that might occur if a $5 or $10 user's fee were imposed.

To estimate the additional costs involved in establishing and administering a user's fee program, we used data provided by the Army, the Air Force, and the Bethesda Naval Hospital. These data were based on various assumptions, ranging from manual to automated systems. Collection costs associated with a user's fee that might be incurred at DOD medical facilities' associated base, regional, or service-wide finance and accounting activities were not included in our estimates. We did not develop our own estimates of collection costs since such estimates would depend on the design of a specific fee collection system(s), which has not yet been developed.

We obtained the views of DOD officials to determine whether beneficiaries were unnecessarily using outpatient services. We also compared the use of outpatient services by military beneficiaries to that of a comparable civilian population. We reviewed the use of outpatient services by beneficiaries and met with officials from two Professional Standards Review Organizations that, according to the Health Care Financing Administration's Professional Standards Review Organization Office, were studying the unnecessary use of outpatient services.

To determine a user's fee that would be comparable to fees paid by CHAMPUS beneficiaries, we used two estimates for CHAMPUS

beneficiary outpatient costs: one, as reported by DOD's Office of CHAMPUS (OCHAMPUS), based on the average outpatient cost per visit and a second that we calculated based on CHAMPUS data. We used both estimates because of widely varying results that they produced.

We obtained information on other issues that may affect a decision to impose a user's fee. From 6 health care industry-related associations or organizations, 23 health maintenance organizations, and 15 other health care/health care insurance providers serving federal and private sector civilian beneficiaries, we obtained information on their prior experiences with cost sharing. We were particularly interested in the experience of health maintenance organizations since as prepaid, comprehensive service types of health plans, they are somewhat analogous to DOD's direct care system.

We visited the medical facilities listed below to develop an understanding of how a user's fee might affect health care operations at the service level.

Army

Walter Reed Army Medical Center, Washington, D.C.
Kenner Army Hospital, Fort Lee, Petersburg, Virginia.
U.S. Army Health Clinic, Fort Pickett, Blackstone, Virginia.

Navy

Naval Hospital, Bethesda, Maryland.
Naval Hospital, Patuxent River, Lexington Park, Maryland.
Naval Medical Clinic, Quantico (Marine Corps), Quantico, Virginia.

Air Force

Malcolm Grow USAF Medical Center, Andrews Air Force Base, Camp Springs, Maryland.
USAF Clinic, Bolling Air Force Base, Washington, D.C.
USAF Hospital, Langley Air Force Base, Hampton, Virginia.

In making monetary calculations in this report, we inflated dollars using Consumer Price Index (CPI) data. CPI projections for 1984-88 were obtained from the U.S. Long Term Review-Summer 1984, published by Data Resources, Inc.

Most of the estimates of revenue and costs associated with user's fees were based on DOD data, which we did not independently verify. We believe that such a time-consuming effort would not have been cost effective since we used the data for gross estimating purposes only.

ESTIMATES OF REVENUE THAT COULD BE GENERATED BY A USER'S FEE

Depending on the workload unit on which a fee would be imposed (the workload unit that DOD uses to define an outpatient visit or one that groups visits for the same condition), we estimate that imposing a $5 user's fee in fiscal year 1984 could have generated net revenues of between $231 million and $467 million for the 5-fiscal-year period 1984-88. We estimate that imposing a $10 fee could have generated net revenues of between $700 million and $1.5 billion during the same period.

DOD officials believe that a workload shift from DOD facilities to CHAMPUS would occur if a user's fee were imposed. A Congressional Budget Office report predicts the opposite effect. Our estimates assume no workload shift because (1) quantifying the shifts is difficult and (2) we could find no valid method of predicting the extent of workload shifts from CHAMPUS to DOD facilities.

Table 1 summarizes our estimates of the amount of revenue that could be generated over the 5-fiscal-year period 1984-88 by imposing a user's fee.

Table 1:

Estimated Revenue That Could Be Generated If User's Fee Had Been Imposed On Outpatient Visits (Fiscal Years 1984-88)

	Fee imposed on every clinical encounter		Fee imposed on grouped workload unit	
	$5 fee	$10 fee	$5 fee	$10 fee
	(millions)			
Number of visits	142.09	133.74	67.58	63.80
Gross revenue	$710.5	1,337.4	$337.9	$638.0
Add: cost reductions in DOD medical facilities as a result of decreased utilization[a]	330.6	671.9	166.2	320.2
Deduct: collection costs[b]	(574.4)	(540.9)	(273.1)	(257.9)
Net revenue	$466.7	$1,468.4	$231.0	$700.3

[a]See tables II.5 and III.5.

[b]See tables II.6 and III.6.

The methodology we used to develop our estimates is described in detail in appendix I.

Adjustments to Gross Revenue

Since studies suggest that imposing a user's fee decreases demand for care, our revenue estimates reflect the financial effects such a decrease could have on gross revenue. Moreover, imposing a user's fee program would entail significant additional operating costs, which must be offset against gross revenue.

Decreased Use

Several studies on the effects of cost sharing on the demand for outpatient health care services have found that as the cost to the beneficiary increases, demand will decrease.

Notable among these studies is the Health Insurance Experiment conducted by the Rand Corporation.[3] This study was designed to assess how varying patients' cost of services affected their use of services and their health status. The study took place between 1974 and 1982 and included about 7,700 persons under 62 years of age in six areas of the nation. Although the military population was excluded, the director of the study testified in June 1984 before the Subcommittee on Defense, Senate Committee on Appropriations, that the study results were applicable to nonactive duty military beneficiaries. The study, he stated, involved a representative sample of the population under age 62 and found that different types of people (high income, low income, residents of large cities, residents of small cities) responded similarly to cost sharing.

The study's results indicated that as more of the cost of care is shifted to beneficiaries, their outpatient utilization rates decreased. In general, when compared with full insurance coverage, insurance involving 25-percent copayments by the insured person reduced outpatient utilization by about 20 percent. Based on the study results, we estimate that imposing a $5 or $10 fee at DOD outpatient facilities would decrease utilization, as shown in table 2. As can be seen, the effect of a fee on decreased demand for services diminishes over time if the fee is not increased as health care costs rise.

Table 2:

Estimated Percentage Decrease in Quantity of Services Demanded Using $5 and $10 User's Fee

Year	Decrease in demand (percent)[a] $5 user's fee	$10 user's fee
1984	6.1	12.2
1985	5.8	11.6
1986	5.4	10.8
1987	5.2	10.4
1988	4.9	9.8

[a]Calculation of these percentages is shown on page 28.

Program Administration

In addition to adjusting gross revenue to reflect the financial effects of decreased utilization, costs to operate a user's fee program must also be considered. Costs associated

[3]Robert H. Brook, et al., "The Effects of Coinsurance on the Health of Adults," Rand Corporation (R-3055-HHS), Dec. 1984.

with establishing such a fee program, collecting the fees, and keeping necessary records to track fees on individual, facility, and system-wide levels would vary depending upon how a fee is structured. Under all circumstances, however, the costs would probably be significant.

Imposing a user's fee on outpatient visits would thrust DOD facilities into fee collection activities of a magnitude much greater than that experienced heretofore. For example, based on data provided by the hospital, if such a fee were imposed, we estimate that Walter Reed Army Medical Center's collection transactions could have increased, depending on variables used, to over 490,000 per year, as compared to about 23,000 transactions handled in fiscal year 1983. (See app. IV.)

To effectively manage the number of collection transactions requires considering the cost of

--additional staff to collect a cash fee and/or create bills for delayed payments and to pursue collection of unpaid debts and

--any automatic data processing (ADP) equipment and associated software used to implement fee collection activities.

Costs could also be incurred for security, space, and supplies.

Additional staff would probably be required to handle the significant increase in fee collection activities that an outpatient user's fee would generate. How many additional staff would be required depends on how a fee program is configured. Some facility officials believe that using ADP will lessen the need for staff for fee collection activities, but others do not. The latter group told us that while ADP would help manage, track, and keep records on fee collection, the same number of staff would be required to implement fee collection as in a manual system. Most agreed, however, that if a user's fee limit, such as an annual maximum, were to be introduced, ADP would be almost essential to track beneficiaries' fee expenses on a medical system-wide basis. Our estimates of revenue do not include a user's fee limit.

Additional staff would probably be needed in DOD facilities' associated base, regional, and/or service-wide finance and accounting activities. The finance and accounting organizations try to collect unpaid debts when facilities have exhausted their own debt collection procedures. Unpaid debts could prove to be a significant problem given the magnitude of the present unpaid debt collection problem described to us by hospital officials with military and nonmilitary patients and the number of user's fee collection actions that could be generated. For example, based on fiscal year 1983 activity:

--In about 40 percent of the outpatient cases that required payment at the Bethesda Naval Hospital, at least one letter requesting payment had to be written after a bill had been sent. Even after collection letters are sent, about 5 percent of the cases requiring payment were eventually forwarded to the Naval Medical Command's accounting and finance function for collection.

--In about 75 percent of all cases that required payment at the Naval Medical Clinic, Quantico--where most of the caseload involved outpatients--letter(s) had to be sent requesting payment; in about 2 percent of the cases, the accounts had to be written off.

--At the Kenner Army Hospital, letters had to be written requesting payment in about 65 percent of cases requiring payment, second follow-up letters are required in about 35 percent of the cases, and 15 percent of the cases are sent to the Accounting and Finance Office for collection.

It may not be cost effective to pursue unpaid outpatient visit user's fees because the collection cost could exceed amounts to be collected. Currently, unpaid debts below specified limits are not pursued by the services because the cost of collection is too high relative to their value. The Army sets that limit at $25. The Navy's policy is that the cost of collection generally should not exceed the amount to be collected. The policy allows the limit to be determined locally by the commanding officer, considering such factors as the amount, the ease of collection, and the ability of the debtor to pay. Commanding officers are given the authority to write off debts of $300 or less or the cost of one occupied bed day, whichever is greater. The Air Force does not generally pursue debts of $25 or less except for active duty members or retirees. These amounts are of interest since any user's fee is likely to be less than $25 per outpatient visit and, consequently, within the range considered not to be cost effective to pursue by the services.

Although we were not able to precisely estimate the cost of pursuing unpaid debts by the services' accounting and finance functions, we obtained two estimates that help put the cost of fee collection activities into perspective. A fiscal and supply official at the Naval Hospital, Patuxent River, told us that sending a bill for outpatient care costs about $16. This includes the cost of salaries and materials, but not a pro-rata share of overhead expenses. A financial and material management official at the Bethesda Naval Hospital estimated that producing and mailing a bill for inpatient or outpatient care costs about $25.

It also appears that the ADP needs of facilities to implement a user's fee would be great, based upon the magnitude of collection activity that would be expected from such a fee. These needs cannot be quantified until the configuration of the fee program has been determined. Officials at the nine facilities we visited said that, other than the capability to perform beneficiary eligibility checks through the Defense Enrollment Eligibility Reporting System,

--two have ADP for word processing, accounting data compilation, and/or pharmacy management;

--the three medical centers visited have inpatient information management systems; and

--four have no further ADP capabilities.

User's Fee Might Cause Workload Shifts

A user's fee might cause a shift of workload from DOD facilities to CHAMPUS and vice versa. Unlike inpatient services, beneficiaries are not required to obtain prior approval from a DOD medical facility before seeking outpatient care though CHAMPUS. Imposing a user's fee could cause a shift of workload from DOD facilities to CHAMPUS because beneficiaries (1) would no longer receive free outpatient care at those facilities and (2) might perceive that CHAMPUS-provided care is more desirable than that provided by the DOD direct care system and, with the decrease in relative costs caused by a user's fee, CHAMPUS-provided care may become more preferred. Data do not exist to quantify the magnitude of these potential shifts.

In May 1984 the Assistant Secretary of Defense (Health Affairs) testified before the Subcommittee on Defense, House Committee on Appropriations, that a user's fee would drive patients out of DOD facilities and into CHAMPUS. A CHAMPUS official told us that his office has concluded that, if other factors were to remain constant, imposing an outpatient user's fee in the direct care system would cause some direct care workload shift to CHAMPUS. According to this official, this would occur because the primary incentive to use the direct care system--free care--would be gone. CHAMPUS has not quantified the magnitude of this potential shift in demand.

CHAMPUS care may be considered to be qualitatively different from care provided in DOD facilities. Unlike in DOD facilities, CHAMPUS beneficiaries can choose their own health care providers. In addition, according to several service officials, many beneficiaries find that they can obtain care from civilian providers faster than they can in the direct care system. These officials also said that beneficiaries may perceive civilian

care to be superior because of the personalized attention that private health care providers display and the trappings (furniture, equipment, etc.) of the care setting. These perceptions, combined with a decrease in relative costs to the beneficiary between outpatient services provided directly by DOD and those provided under CHAMPUS, may cause a workload shift to CHAMPUS.

Not all the factors involved in imposing a fee would decrease utilization of DOD facilities. In a March 1984 study, the Congressional Budget Office concluded that all of the approximately 1.6 million nonpsychiatric and nonemergency CHAMPUS catchment area visits that it predicted would take place in 1984 could have been absorbed in DOD facilities due to decreased utilization resulting from imposition of an outpatient user's fee. The study stated

> ". . . [m]any CHAMPUS users would probably welcome visiting military physicians if only because they could thus avoid paying the CHAMPUS deductibles. These people would naturally seek direct care as outpatient fees reduce waiting lines among present users."

However, in developing our estimates of revenue that could be generated by imposing a user's fee, we assumed no workload shifts because (1) it would be difficult to quantify the potential workload shifts from DOD facilities to CHAMPUS caused by a user's fee and (2) we could not find a valid method of predicting the extent of workload shifts from CHAMPUS to DOD facilities as predicted by the Congressional Budget Office.

EXTENT OF UNNECESSARY USE OF OUTPATIENT SERVICES

Quantifying the extent to which beneficiaries unnecessarily use outpatient services in DOD medical facilities and the extent to which a user's fee would affect the incidence of unnecessary visits is difficult. This is because there are no generally accepted definitions of, or criteria for measuring, unnecessary use of outpatient services by beneficiaries. Information from DOD officials on the incidence of such unnecessary use was based on personal impressions and anecdotes, neither of which can serve as the basis for definitive conclusions. However, in general, the officials believe that, although some unnecessary use exists in DOD facilities as it may in the civilian sector, such factors as the inability to obtain timely appointments for care and long waiting lines discourage such unnecessary use in DOD facilities.

Our revenue estimates reflect a decrease in use of outpatient services at DOD facilities. Some service officials said

they assume that some of the decreased demand would not adversely affect the health of beneficiaries, while others believed that necessary care may be delayed, especially by those who lack the knowledge or experience to adequately assess the seriousness of a perceived illness or injury. They were particularly concerned that those lacking money to pay a user's fee may not seek needed care.

USER'S FEE COMPARABLE TO CHARGES PAID BY CHAMPUS BENEFICIARIES

Sufficient data do not exist to precisely determine what user's fee amount would be necessary for outpatient visits at DOD medical facilities to achieve comparability with outpatient service charges paid by beneficiaries under CHAMPUS. Based on available data, a user's fee as low as $16 to as high as $30 per visit would be necessary to make the direct care charges comparable to that paid under CHAMPUS.

Currently, beneficiaries incur no charge for outpatient care at DOD medical facilities, while CHAMPUS users incur deductible and coinsurance expenses. For dependents of active duty sponsors, the deductible is $50 per individual or $100 per family for each fiscal year and the coinsurance rate is 20 percent. For retirees and their dependents as well as survivors, the deductible amounts are the same but the coinsurance rate is 25 percent.

According to OCHAMPUS, the average overall cost of a CHAMPUS outpatient visit was $78 in fiscal year 1983. OCHAMPUS estimates that of that amount, about $30 was the average cost to the beneficiary.

Our calculation of the average patient cost per outpatient visit based on the coinsurance rates results in a significantly lower estimate. Applying the coinsurance rates of 20 to 25 percent to the average total cost of a CHAMPUS visit of $78 in fiscal year 1983 results in average patient costs per visit of about $16 for dependents of active duty members and $20 for retirees, their dependents, and survivors. These calculations do not consider deductibles or nonallowable expenses for which claims are filed. However, a CHAMPUS official told us that an analysis of disallowed expenses for outpatient visit claims over a 3-month period during 1984 showed that over 90 percent of billed charges were allowed. Consequently, nonallowable expenses may not be a major complicating factor in calculating costs for outpatient visits.

OTHER FACTORS CONCERNING IMPOSITION OF USER'S FEE

DOD opposes a user's fee, believing that it could worsen beneficiaries' financial position and adversely affect morale, recruitment, retention, and readiness. DOD did not provide any data to support this belief. While the financial impact of a user's fee will differ among beneficiaries according to their financial circumstances, on the average a user's fee of $5 or $10 would represent only a small percentage of family income.

The impact of a user's fee on non-DOD federal medical facilities should also be considered in structuring a fee program. In addition to being authorized medical care in DOD facilities, DOD beneficiaries also have access to other non-DOD uniformed service facilities, including those of the Coast Guard and the former Public Health Service hospitals. If a user's fee is imposed at DOD facilities only, beneficiaries may use the other uniformed service facilities to avoid paying the fee.

Effect on Beneficiaries' Financial Status

As shown in table 3, we estimate that, on the average, user's fees incurred in any one year would in all cases represent less than 1 percent of the annual income of the military sponsor--the active duty or retired member. Family income data were not available.

Table 3:

Family Estimated Average User's Fee Expenses as a Percent of Sponsor's Income

Sponsor type (income level)	Approximate annual income of sponsor[a]	User's fee expenses as a percent of sponsor's income[b]			
		$5 fee		$10 fee	
		RAPS rates[c]	Survey rates[d]	RAPS rates[c]	Survey rates[d]
		(percent)			
Active duty:					
Enlisted (low)	$11,000	0.05	0.02	0.08	0.04
Enlisted (average)	16,600	.21	.10	.36	.18
Enlisted (high)	34,800	.18	.09	.30	.15
Officer (low)	20,500	.12	.06	.20	.10
Officer (average)	35,800	.17	.08	.29	.14
Officer (high)	60,200	.21	.10	.35	.17
Retirees:					
Enlisted (average)	25,900	.21	.10	.37	.17
Officer (average)	47,400	.11	.05	.18	.08

[a]For active duty, "approximate annual income" refers to basic military compensation. For retirees, it refers to average postservice earnings in 1981 for those retiring between 1972 and 1980 plus average military pensions as of September 30, 1981, inflated to 1984 dollars.

[b]Calculated by dividing average estimated family expenses for user's fees by sponsor's annual income.

[c]Based on DOD definition of outpatient visit.

[d]Based on grouped workload definition for outpatient visit.

The average projected percentages of income that would be spent by military families on user's fees are generally much lower than the percentages spent by civilian families of comparable income levels on outpatient care. Table 4 shows the percentage of income civilians spend on outpatient care.

Table 4:

Outpatient Medical Expenses as a Percent of Family Income in the Civilian Sector[a]

Income level[b]	Outpatient expenses as percent of income[c]				
	0	.01-1	1.01-5	5.01-10	More than 10
	(percent)				
$0 - $10,601	24	11	16	13	35
$10,602 - $13,251	13	14	26	24	23
$13,252 - $21,202	7	14	40	25	15
$21,203 - $42,404	4	20	52	18	5
$42,405 and above	3	40	52	5	[d]
Average for all categories	7	24	44	15	10

[a]Data are for a family of four. Source: National Health Care Expenditures Study, National Center for Health Services Research, Office of Health Research, Statistics and Technology, Public Health Service, U.S. Department of Health and Human Services 1977-78.

[b]1977 data found in the study were inflated to 1984 dollars.

[c]May not add to 100 percent because of rounding.

[d]Less than 1.

A comparison between (1) the estimates of what beneficiaries would spend on user's fees (table 3) and (2) outpatient medical expenses of civilians (table 4) shows that:

--An enlisted person with an average annual income of $16,600 would spend between 0.10 and 0.36 percent on user's fees; 80 percent of a comparable group in the civilian sector would spend 1.01 percent or more on outpatient care.

--An officer with an average annual income of $35,800 would spend between 0.08 and 0.29 percent on user's fees; 75 percent of a comparable group in the civilian sector would spend 1.01 percent or more on outpatient care.

--A retired enlisted person with an average annual income of $25,900 would spend between 0.10 and 0.37 percent on user's fees; 75 percent of a comparable civilian group would spend 1.01 or more on outpatient care.

--A retired officer with an average annual income of $47,400 would spend between 0.05 and 0.18 percent on user's fees; about 58 percent of a comparable civilian group would spend 1.01 percent or more on outpatient care.

Effect on the Military Mission

Some DOD officials expressed concern that imposing a user's fee will harm (1) morale among military members and other beneficiaries, (2) recruitment efforts, (3) retention levels, and (4) the military's readiness posture. Imposing a user's fee could adversely affect morale among those in the military community since it could be perceived as a loss in total compensation and an erosion of benefits. Data do not exist to conclusively corroborate the concerns about recruitment, retention, or military readiness.

Only active duty members are entitled by law to be provided free medical care; other beneficiaries are authorized care in DOD medical facilities on a space-available basis. Many officials of the military community contend that military persons have been led to believe from recruitment literature and historical practice that health care, and even free health care, would be provided to them and their families throughout their careers and retirement by the military medical care system. This was discussed in a 1974 House Committee on Armed Services' report and in a February 1979 Defense Resources Management Study. The 1974 Committee report characterized providing medical care to retirees and their dependents as a high moral obligation of the military based on promises the services made to military persons over the years as inducements to enlist, reenlist, and make careers in the military. The promises, according to the report, were that the retiree and his/her family need not worry about medical care because it would be available to them in military facilities. The 1979 study stated that inaccurate, vague, or misleading recruiting and advertising literature contributed substantially to beneficiaries' false expectations and frustration.

The potential loss of benefits represented by a user's fee could be taking place at the same time as other perceived erosions of military persons' benefits, such as efforts to change the military retirement system. Consequently, imposing an outpatient user's fee could contribute to a cumulative decline in the morale of service people and their families. It should be noted, however, that cost sharing in various forms is being used increasingly in the private sector.

DOD did not provide data to corroborate the concern about a user's fee's impact on recruitment, retention, and military readiness. We believe, however, that the following discussion puts these concerns in perspective.

Regarding recruitment, we note that most recruits are young, they lack dependents, and many may not have had any health care insurance upon enlistment. To those with dependents, a user's fee would probably appear to be a relatively small payment, particularly in light of the relatively high health care costs prevalent in the private sector. In addition, to new members a user's fee would not represent a retraction of previous benefits.

Regarding retention, surveys indicate that health care is an important consideration in retention decisions, and a fee could constitute an erosion of benefits and reduced total compensation to active duty members. A question remains, however, as to whether the small fees of $5 or $10 that have been discussed would cause many persons to abandon their careers and their associated benefits. As shown in table 4, a $5 user's fee imposed on members of an active duty family of an enlisted member with average income would total 0.10 to 0.21 percent of their income. Families of average income active duty officers would incur outpatient user's fee expenses totaling 0.08 to 0.17 percent of their income.

Regarding readiness, military officials expressed concern that a user's fee could narrow the caseload mix in DOD facilities, consequently impairing physician training. Yet, the caseload mix of DOD facilities during peacetime is very different from the mix in wartime. The military's peacetime workload primarily involves dependent care, while the workload during wartime will be surgery intensive.

Effect on Non-DOD Uniformed Services Treatment Facilities

Chapter 55, title 10, of the U.S. Code grants active duty members, retired members, and their dependents and survivors access to care in facilities of the uniformed services. The uniformed services include the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the Public Health Service (PHS), and the National Oceanic and Atmospheric Administration (NOAA). DOD, the Coast Guard, and PHS operate full service health care facilities; NOAA operates clinics that do not provide a full range of services. The Secretary of Defense administers the chapter for the armed forces under his jurisdiction, and the Secretary of Health and Human Services administers it for the Coast Guard when not operating as a service in the Navy, as well as for PHS and NOAA.

If a fee were imposed only at DOD facilities, beneficiaries could turn to Coast Guard facilities to avoid paying the user's fee. We did not consider whether DOD beneficiaries might use PHS facilities since PHS operates only about 50 small facilities

in remote areas on American Indian reservations, a research-oriented hospital in conjunction with the National Institutes of Health, a hospital for victims of Hansen's Disease, and a mental hospital in the District of Columbia. Alternatively, Coast Guard beneficiaries might be required to pay a user's fee at DOD facilities but not at those of their parent service. Many DOD beneficiaries residing within the outpatient catchment areas of Coast Guard facilities could avail themselves of those facilities' outpatient services. Analysis of data provided by the Defense Enrollment Eligibility Reporting System's Support Office shows that almost 1 million nonactive duty DOD beneficiaries reside within the catchment areas of 24 principal Coast Guard facilities in the United States (excluding Puerto Rico).

In addition, any outpatient user's fee imposed at DOD medical facilities should be extended to the former PHS hospitals operating under state, local, or private control. Public Law 97-99 provides that these hospitals and clinics are facilities of the uniformed services for purposes of chapter 55, title 10, of the U.S. Code. If no fee were to be imposed at these facilities, beneficiaries might use them to avoid paying the user's fee. In fiscal year 1984, DOD beneficiaries made about 430,000 visits to the former PHS facilities.

DOD COMMENTS AND OUR EVALUATION

In commenting on a draft of this report on June 12, 1986 (see app. V), the Assistant Secretary of Defense (Health Affairs) agreed that it was difficult to make reasonably accurate estimates of revenue that a user's fee might generate. According to the Assistant Secretary, the Department is reluctant to take any action to impose a fee until it is able to obtain more reliable information regarding several issues related to the imposition of a fee. He further stated that, while the assumptions we made may be reasonable, the degree of reliability of data we used was not sufficiently high to support a decision on whether to impose a user's fee. He said, therefore, that DOD would conduct a feasibility study in fiscal year 1987 to include an assessment of all available data in both the government and civilian sectors and that action would be taken to implement a fee either on a test or global basis if the results of the study indicate that a fee would be feasible and beneficial.

Although DOD believes that further study is needed before it decides whether to impose a user's fee, it should be noted that reliable data do not exist regarding many of the factors related to the imposition of a fee. Thus, we believe that a feasibility study initiated by DOD should be directed first toward (1) establishing specific objectives for a user's fee program and (2) determining the amount of a fee that would be needed to achieve those objectives.

METHODOLOGY USED TO CALCULATE REVENUES GENERATED BY IMPOSING A USER'S FEE ON OUTPATIENT MEDICAL SERVICES AT DOD TREATMENT FACILITIES

Calculations of estimated revenues that could be generated by imposing a user's fee on outpatient services at DOD medical treatment facilities are based on fee amounts of $5 and $10 per visit. Our estimates used two definitions of an outpatient visit--(1) the services' cost accounting system definition of an outpatient visit (every clinical encounter) and (2) a grouped workload unit definition based on data in a 1978 DOD survey of beneficiaries. Our estimates were made for fiscal years 1984-88, inclusive.

CALCULATION OF GROSS REVENUE

Gross revenue was calculated by multiplying estimates of future utilization by possible fee amounts--$5 and $10 per visit. Estimates of future utilization were developed in a two-step process. The first step was estimating the total number of outpatient visits if no user's fee were imposed. Data for this calculation were obtained from (1) reports generated from UCA and (2) the 1978 Military Health Services Utilization Survey by the Office of the Assistant Secretary of Defense (Health Affairs). Using these data, we applied the utilization rates--expressed in outpatient visits per person per year--to the estimated population. Tables II.1 and III.1 show the results of this process.

The second step in calculating future utilization involved an adjustment to reflect a decrease in demand caused by imposing a user's fee. To calculate the estimated percentage decrease in demand for outpatient services associated with a $5 and $10 user's fee, we used data from the Health Insurance Experiment by the Rand Corporation.[1]

Table I.1 shows the decline the study reported in individuals' outpatient visits when coinsurance was introduced into a previously free health plan.

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[1]Joseph P. Newhouse, et al., "Some Interim Results From a Controlled Trial of Cost Sharing in Health Insurance," New England Journal of Medicine, Dec. 17, 1981; pages 1501-1507.

Table I.1:

Demand for Outpatient Care
When Coinsurance Is Introduced
(Calendar Year 1976)

Coinsurance	Individual expenditures per year	Number of visits	Cost per visit	Coinsurance	Decrease in number of visits (percent)
None	$188.00	5.4	$34.81	$ 0	
25%	146.64	4.4	33.33	8.33	18.5
50%	110.92	3.2	34.66	17.33	40.7

Note: Data are from a study site in Dayton, Ohio, in year 2 of the experiment. The researchers state that these values are consistent with national data.

Using CPI values, we inflated the 1976 coinsurance amounts as shown in table I.2.

Table I.2:

Coinsurance Amounts (1979 Inflated to 1988)

Year	Charge of 25-percent coinsurance
1976	$ 8.33
1984	15.27
1985	16.05
1986	16.98
1987	17.95
1988	19.00

Since a 25-percent coinsurance charge of $8.33 in 1976, or $15.27 in 1984, was associated with a reduction in utilization of 18.5 percent, we developed the following equation to calculate the percentage decrease in utilization associated with a $5 charge in 1984:

$$\frac{X}{\$5} = \frac{18.5\%}{\$15.27}$$

$$X = 6.1\%$$

Assuming a constant price elasticity over the $0 to $15.27 range, we used a similar equation to determine the effects of a $10 fee on utilization. The equation used to determine the percentage decrease in utilization associated with a $10 charge in 1984 was:

$$\frac{X}{\$10} = \frac{18.5\%}{\$15.27}$$

$$X = 12.2\%$$

Using these basic equations, we calculated the percentages of change in utilization associated with a $5 or $10 user's fee by year, as shown below.

Table I.3:

Percentage Decrease in Utilization Associated With a $5 and $10 User's Fee by Year

Year	$5 fee	$10 fee
	-------(percent)-------	
1984	6.1	12.2
1985	5.8	11.6
1986	5.4	10.8
1987	5.2	10.4
1988	4.9	9.8

To calculate gross revenue, we multiplied the total number of estimated outpatient visits, adjusted to reflect the decrease in demand, to user fees of $5 and $10 per visit. (See tables II.2, II.3, III.2 and III.3.)

ADJUSTMENTS TO GROSS REVENUE

Since a user's fee may cause some decreased use of outpatient services, an adjustment to gross revenue is necessary to reflect the financial effects this action might have. Moreover, a user's fee will significantly affect the collection efforts at DOD facilities and result in increased costs, which must be offset against gross revenue.

Adjustments to Reflect Effects of Decreased Use

To calculate the number effects of a decrease in outpatient visits as a result of a user's fee, we applied $5 and $10 fees to the difference between (1) the number of outpatient visits expected with no user's fee and (2) the number of visits expected with a fee. (See tables II.4 and III.4.)

To quantify the financial effect associated with decreased use, we identified the cost of an additional outpatient visit in DOD facilities. In calculating the savings or costs to DOD facilities, we used estimates of the marginal cost of an outpatient visit cited in the December 1975 Military Health Care Study.[2] This study identified marginal to average cost ratios of 0.50, 0.75, and 0.96. We used 0.75 because it was in the middle of the ratios identified. Applying this ratio to the 1984 DOD treatment facility average cost per outpatient visit of $49 established by the Office of Management and Budget for interagency reimbursement purposes resulted in a marginal cost per outpatient visit in a military treatment facility of $36.75. We used this amount for 1984 and, using CPI data, inflated it each year to 1988. Tables II.5 and III.5 show the financial effects of decreased use.

Adjustments for Collection Costs

A user's fee may significantly increase DOD treatment facility fee collection activities. This activity is now limited primarily to collecting fees imposed on inpatients. Two of the services and one naval hospital we contacted had previously developed estimates of user's fee collection costs. These estimates were made in conjunction with analyses to measure the impact of such a fee when it was being considered several years ago. These estimates were: Army, $5.23 per collection (FY 1984 cost); Bethesda Naval Hospital, $2.07 per collection (FY 1983 cost); and Air Force, $3.26 per collection (FY 1983 cost).

A uniform methodology was not used to develop these estimates; this may partly account for the differences between the services. For example, the Air Force's estimate projects about 11 million outpatient visits and includes costs for additional personnel, facility modifications, supplies, collection costs for delinquent accounts, and ADP equipment and support. By contrast, the Army's estimate was calculated on the basis of the average time currently associated with a cash collection multiplied by the average hourly pay rate for government employees.

Using CPI data, we inflated the services' estimates as shown in table I.4.

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[2]Department of Defense, Department of Health, Education, and Welfare, Office of Management and Budget, Report of the Military Health Care Study - Supplement; Detailed Findings, December 1975.

Table I.4:

Estimated Cost Per Collection
(Fiscal Years 1984-88)

Fiscal year	Cost per collection			
	Army	Bethesda	Air Force	Average
1984	$5.23	$2.18	$3.43	$3.61
1985	5.50	2.29	3.60	3.80
1986	5.82	2.42	3.81	4.02
1987	6.15	2.56	4.03	4.25
1988	6.51	2.71	4.26	4.49

We applied the overall average costs, by year, to the estimated number of outpatient visits expected in order to develop an estimate of the collection costs. (See tables II.6 and III.6.)

APPENDIX II

DATA USED TO DEVELOP ESTIMATES OF REVENUES IF A USER'S FEE WERE IMPOSED ON EVERY CLINICAL ENCOUNTER[1]

Table II.1:

Estimated Number of Outpatient Visits to Military Treatment Facilities Worldwide Based on RAPS If No User's Fee Is Imposed (Fiscal Years 1984-88)

Fiscal year	Population		RAPS utilization rate[a]		Estimated number of visits[b]		
	Active duty dependents	Other	Active duty dependents	Other	Active duty dependents	Other	Total
	----(millions)----				--------(millions)--------		
1984	2.50	2.81	7.0	4.1	17.47	11.53	29.00
1985	2.55	2.86	7.0	4.1	17.86	11.74	29.60
1986	2.60	2.91	7.0	4.1	18.19	11.94	30.13
1987	2.62	2.96	7.0	4.1	18.37	12.13	30.50
1988	2.66	3.01	7.0	4.1	18.63	12.32	30.96
Total					90.53	59.66	150.19

[a]Expressed in outpatient visits per person per year.

[b]Column and row totals may not add due to rounding.

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[1]Source of data for all tables is DOD's Resource Analysis and Planning System (RAPS).

Table II.2:

Estimated Changes in RAPS Utilization Rates[a] If User's Fee Imposed (Fiscal Years 1984-88)

Fiscal year	Utilization rate with no fee	Rate decrease[b] $5 fee	Rate decrease[b] $10 fee	Utilization rate with a fee $5 fee	Utilization rate with a fee $10 fee
Active duty dependents					
1984	7.0	0.427 (6.1%)	0.854 (12.2%)	6.6	6.1
1985	7.0	.406 (5.8%)	.812 (11.6)	6.6	6.2
1986	7.0	.378 (5.4%)	.756 (10.8%)	6.6	6.2
1987	7.0	.364 (5.2%)	.728 (10.4%)	6.6	6.3
1988	7.0	.343 (4.9%)	.686 (9.8%)	6.7	6.3
Other beneficiaries					
1984	4.1	.250 (6.1%)	.500 (12.2%)	3.8	3.6
1985	4.1	.238 (5.8%)	.476 (11.6%)	3.9	3.6
1986	4.1	.221 (5.4%)	.443 (10.8%)	3.9	3.7
1987	4.1	.213 (5.2%)	.426 (10.4%)	3.9	3.7
1988	4.1	.201 (4.9%)	.402 (9.8%)	3.9	3.7

[a]Expressed in outpatient visits per person per year.

[b]Based on estimated percentages of decreased utilization discussed in appendix I.

Table II.3:

Estimated Number of Outpatient Visits to Military Treatment Facilities Worldwide Based on RAPS If User's Fee Imposed (Fiscal Years 1984-88)

Fiscal year	Population[a]	Utilization rate with a fee[b]		Outpatient visits with a fee[c]	
		$5 fee	$10 fee	$5 fee	$10 fee
	(millions)			----(millions)---	
Active duty dependents					
1984	2.50	6.6	6.1	16.48	15.23
1985	2.55	6.6	6.2	16.84	15.82
1986	2.60	6.6	6.2	17.15	16.11
1987	2.62	6.6	6.3	17.32	16.53
1988	2.66	6.7	6.3	17.84	16.77
Subtotal				85.62	80.46
Other beneficiaries					
1984	2.81	3.8	3.6	10.68	10.12
1985	2.86	3.9	3.6	11.17	10.31
1986	2.91	3.9	3.7	11.36	10.78
1987	2.96	3.9	3.7	11.54	10.94
1988	3.01	3.9	3.7	11.72	11.12
Subtotal				56.47	53.28
Total				142.09	133.74

[a]Source: Table II.1.

[b]Source: Table II.2.

[c]Column and row totals may not add because of rounding.

Table II.4:

Reduction in Outpatient Visits as a Result of Imposing a User's Fee Based on RAPS

Fiscal year	Visits without fee[a]	Visits with fee[b,c]		Visits reduced[c]	
		$5 fee	$10 fee	$5 fee	$10 fee
	(millions)	---(millions)--		---(millions)--	
1984	29.00	27.16	25.35	1.84	3.65
1985	29.60	28.01	26.13	1.60	3.47
1986	30.13	28.51	26.89	1.62	3.24
1987	30.50	28.86	27.48	1.64	3.02
1988	30.96	29.56	27.89	1.40	3.07
	150.19	142.09	133.74	8.10	16.46

[a]Source: Table II.1.

[b]Source: Table II.2.

[c]Column and row totals may not add because of rounding.

Table II.5:

Cost Reductions as a Result of Reduction in Outpatient Visits Based on RAPS Data

Fiscal year	Visits reduced[a]		Cost per visit[b]	Cost reductions	
	$5 fee	$10 fee		$5 fee	$10 fee
	---(millions)----			---(millions)----	
1984	1.84	3.65	$36.75	$ 67.62	$134.14
1985	1.60	3.47	38.67	61.87	134.18
1986	1.62	3.24	40.88	66.23	132.45
1987	1.64	3.02	43.22	70.88	130.52
1988	1.40	3.07	45.73	64.02	140.39
Total	8.10	16.46		$330.62	$671.68

[a]Source: Table II.4.

[b]See p. 29.

Table II.6:

Estimated Collection Costs If User's Fee Is Imposed Based on RAPS Utilization Rates

Fiscal year	Number of visits		Collection cost per visit[b]	Collection costs[c]	
	$5 fee	$10 fee		$5 fee	$10 fee
	---(millions)----			---(millions)----	
1984	27.16	25.35	$3.61	$ 98.04	$ 91.51
1985	28.01	26.13	3.80	106.44	99.29
1986	28.51	26.89	4.02	114.61	108.09
1987	28.86	27.48	4.25	122.64	116.78
1988	29.56	27.89	4.49	132.72	125.23
Total	142.09	133.74		$574.45	$540.91

[a]Source: Table II.4.

[b]Based on average of services' fiscal year 1983 collection costs and inflated for subsequent years (see p. 30).

[c]Column and row totals may not add because of rounding.

DATA USED TO DEVELOP ESTIMATES OF REVENUES IF A USER'S FEE WERE IMPOSED ON GROUPED WORKLOAD UNITS[1]

Table III.1:

Estimated Number of Outpatient Visits to Military Treatment Facilities Worldwide Based on 1978 Survey If No User's Fee Is Imposed (Fiscal Years 1984-88)

Fiscal year	Population		1978 survey utilization rate[a]		Estimated number of visits[b]		
	Active duty dependents	Other	Active duty dependents	Other	Active duty dependents	Other	Total
	----(millions)----				---------(millions)--------		
1984	2.50	2.81	3.4	1.9	8.49	5.34	13.83
1985	2.55	2.86	3.4	1.9	8.68	5.44	14.12
1986	2.60	2.91	3.4	1.9	8.83	5.53	14.37
1987	2.62	2.96	3.4	1.9	8.92	5.62	14.54
1988	2.66	3.01	3.4	1.9	9.05	5.71	14.76
Total					43.97	27.65	71.62

[a]Expressed in outpatient visits per person per year.

[b]Column and row totals may not add due to rounding.

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[1]Basis of data for all tables is the 1978 Military Health Services Utilization Survey, Office of the Assistant Secretary of Defense (Health Affairs).

Table III.2:

Estimated Changes in 1978 Survey Utilization Rates[a] If User's Fee Imposed (Fiscal Years 1984-88)

Fiscal year	Utilization rate with no fee	Rate decrease[b] $5 fee	Rate decrease[b] $10 fee	Utilization rate with a fee $5 fee	Utilization rate with a fee $10 fee
Active duty dependents					
1984	3.4	0.207 (6.1%)	0.415 (12.2%)	3.2	3.0
1985	3.4	.197 (5.8%)	.394 (11.6%)	3.2	3.0
1986	3.4	.184 (5.4%)	.367 (10.8%)	3.2	3.0
1987	3.4	.177 (5.2%)	.354 (10.4%)	3.2	3.0
1988	3.4	.167 (4.9%)	.333 (9.8%)	3.2	3.1
Other beneficiaries					
1984	1.9	.116 (6.1%)	.232 (12.2%)	1.8	1.7
1985	1.9	.110 (5.8%)	.220 (11.6%)	1.8	1.7
1986	1.9	.103 (5.4%)	.205 (10.8%)	1.8	1.7
1987	1.9	.099 (5.2%)	.198 (10.4%)	1.8	1.7
1988	1.9	.093 (4.9%)	.186 (9.8%)	1.8	1.7

[a]Expressed in outpatient visits per person per year.

[b]Based on estimated percentages of decreased utilization discussed in appendix I.

Table III.3:

Estimated Number of Outpatient Visits to Military Treatment Facilities Worldwide Based on 1978 Survey If User's Fee Imposed (Fiscal Years 1984-88)

Fiscal year	Population[a]	Utilization rate with a fee[b]		Outpatient visits with a fee[c]	
		$5 fee	$10 fee	$5 fee	$10 fee
	(millions)			----(millions)---	
Active duty dependents					
1984	2.50	3.2	3.0	7.99	7.49
1985	2.55	3.2	3.0	8.16	7.65
1986	2.60	3.2	3.0	8.31	7.80
1987	2.62	3.2	3.0	8.40	7.87
1988	2.66	3.2	3.1	8.52	8.25
Subtotal				41.38	39.06
Other beneficiaries					
1984	2.81	1.8	1.7	5.06	4.78
1985	2.86	1.8	1.7	5.16	4.87
1986	2.91	1.8	1.7	5.24	4.95
1987	2.96	1.8	1.7	5.32	5.03
1988	3.01	1.8	1.7	5.41	5.11
Subtotal				26.19	24.74
Total				67.58	63.80

[a]Source: Table III.1.

[b]Source: Table III.2.

[c]Column and row totals may not add because of rounding.

Table III.4:

Reduction in Outpatient Visits as a Result of Imposing a User's Fee Based on 1978 Survey

Fiscal year	Visits without fee[a]	Visits with fee[b,c]		Visits reduced[c]	
		$5 fee	$10 fee	$5 fee	$10 fee
	(millions)	---(millions)--		---(millions)--	
1984	13.83	13.05	12.27	0.78	1.56
1985	14.12	13.32	12.52	.80	1.59
1986	14.37	13.56	12.75	.81	1.62
1987	14.54	13.72	12.90	.82	1.64
1988	14.76	13.93	13.36	.83	1.40
Total	71.62	67.58	63.80	4.04	7.82

[a]Source: Table III.1.

[b]Source: Table III.3.

[c]Column and row totals may not add because of rounding.

Table III.5:

Cost Reductions as a Result of Reduction in Outpatient Visits Based on 1978 Survey Data

Fiscal year	Visits reduced[a]		Cost per visit[b]	Cost reductions[c]	
	$5 fee	$10 fee		$5 fee	$10 fee
	---(millions)----			---(millions)----	
1984	0.78	1.56	$36.75	$ 28.67	$ 57.33
1985	.80	1.59	38.67	30.94	61.49
1986	.81	1.62	40.88	33.11	66.23
1987	.82	1.64	43.22	35.44	70.88
1988	.83	1.40	45.73	38.96	64.02
Total	4.04	7.82		$166.12	$319.95

[a]Source: Table III.4.

[b]See p. 29.

[c]Column and row totals may not add because of rounding.

Table III.6:

Estimated Collection Costs
If User's Fee Is Imposed
Based on 1978 Survey Utilization Rates

Fiscal year	Number of visits		Collection cost per visit[b]	Collection costs[c]	
	$5 fee	$10 fee		$5 fee	$10 fee
	---(millions)----			---(millions)----	
1984	13.05	12.27	$3.61	$ 47.11	$ 44.29
1985	13.32	12.52	3.80	50.62	47.59
1986	13.56	12.75	4.02	54.50	51.24
1987	13.72	12.90	4.25	58.32	54.83
1988	13.93	13.36	4.49	62.54	60.00
Total	67.58	63.80		$273.09	$257.95

[a]Source: Table III.4.

[b]Based on average of services' fiscal year 1983 collection costs and inflated for subsequent years (see p. 30).

[c]Column and row totals may not add because of rounding.

FISCAL YEAR 1983 ESTIMATED FEE COLLECTIONS AT SELECTED FACILITIES WITH AND WITHOUT A USER'S FEE-- AIR FORCE, NAVY, AND ARMY

Table IV.1:

Fiscal Year 1983 Estimated Collections at Selected Facilities With and Without a User's Fee--Air Force

Facility	Actual collections		Estimated collections if user's fee imposed	
	Inpatient admissions[a]	Nonmilitary outpatient visits[b]	$5 fee	$10 fee
Malcolm Grow USAF Medical Center	10,213	4,088	249,907[c]	232,820[c]
USAF Clinic, Bolling Air Force Base	0	0	35,381[d]	32,962[d]
USAF Hospital-Langley Air Force Base	5,234	60	180,580	168,232

[a]Represents daily fees required to be paid by nonactive duty beneficiaries while inpatients.

[b]Represents fees paid for outpatient care, such as medical emergencies, to non-DOD beneficiaries.

[c]Based on data for calendar year 1983. Excludes estimated visits at Bolling Clinic.

[d]Based on estimates provided by Malcolm Grow officials.

Table IV.2:

Fiscal Year 1983 Estimated Collections at Selected Facilities With and Without a User's Fee--Navy

Facility	Actual collections: Inpatient admissions[a]	Actual collections: Nonmilitary outpatient visits[b]	Estimated collections if user's fee imposed: $5 fee	Estimated collections if user's fee imposed: $10 fee
Naval Hospital, Bethesda	15,977	1,134	316,594	294,946
Naval Hospital, Patuxent River	1,179	52[c]	51,472	47,952
Naval Medical Clinic, Quantico	224[d]	15	58,536	54,533

[a]Represents daily fees required to be paid by nonactive duty beneficiaries while inpatients.

[b]Represents fees paid for outpatient care, such as medical emergencies, to non-DOD beneficiaries.

[c]Based on experience during first half of fiscal year 1984.

[d]Based on billed admissions October 1982 through July 1983.

Table IV.3:

Fiscal Year 1983 Estimated Collections at Selected Facilities With and Without a User's Fee--Army

Facility	Actual collections: Inpatient admissions[a]	Actual collections: Nonmilitary outpatient visits[b]	Estimated collections if user's fee imposed: $5 fee	Estimated collections if user's fee imposed: $10 fee
Walter Reed Army Medical Center	22,739	52	471,237	439,015
Kenner Army Hospital	4,010	5,040	98,170[c]	91,457
U.S. Army Health Clinic, Ft. Pickett	0	0	3,015	2,809

[a]Represents daily fees required to be paid by nonactive duty beneficiaries while inpatients.

[b]Represents fees paid for outpatient care, such as medical emergencies, to non-DOD beneficiaries.

[c]Based on data for April 1983 through March 1984.

ADVANCE COMMENTS FROM THE

DEPARTMENT OF DEFENSE

HEALTH AFFAIRS

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON D.C. 20301

12 JUN 1986

Mr. Frank C. Conahan
Director, National Security and
International Affairs Division
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Conahan:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report entitled, "Implications of Imposing An Outpatient User Fee For Nonactive Duty DoD Beneficiaries," dated April 9, 1986 (GAO Code 101082/OSD Case 6986).

The DoD concurs in your assessment of the difficulty in obtaining the information needed to make reasonably accurate estimates of the revenue that could be generated by imposing a user's fee on outpatient care in the direct care system. Therefore, the Department is reluctant to take any action to impose a fee until it is able to obtain more reliable information with regard to:

a. how a user's fee might affect utilization;

b. if a user's fee does affect utilization, at what level should it be set to have a deterrent effect, yet not discourage beneficiaries from seeking necessary medical care;

c. the amount of net revenue that could be expected after the cost of administration is considered;

d. the appropriate work unit to which the charge should be applied; and

e. the military compensation context in which the changes would occur.

While the assumptions made by the GAO regarding this kind of information may be reasonable, the degree of reliability of the data is not sufficiently high to support a decision at this time.

The DoD, therefore, proposes to conduct a feasibility study in FY 1987 to include an assessment of all available data in both the Government and civilian sectors. If the assessment of

available data indicate that implementation of a user charge is feasible and beneficial, HCFA will be taken to implement such a charge either on a trial or full basis.

Thank you for the opportunity to comment on the draft report.

Sincerely,

William Mayer, M.D.

(101082)

END

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